Union Pointe Academy
ADMINISTRATION OF MEDICATION

School policy requires consent of parent/legal guardian and a written order from a licensed prescriber before medication can be administered to a student during the school day. The following information is necessary in order to comply with this policy.

ALL ITEMS MUST BE COMPLETED IN FULL. Please return the completed form to the school office.

THIS SECTION IS TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student	Date of Birth	Grade	Homeroom

Address _____ Telephone _____

I give my permission for school personnel designated to administer the medication to my child as prescribed above, and further agree to the following:

1. Submit to school personnel a revised written statement signed by the licensed prescriber if the medication, dosage, schedule is changed or eliminated.
2. Grant permission for the school to confer with the licensed prescriber regarding my child's health and treatment issues as they pertain to this medication/procedure/diagnosis and his/her behavioral management needs.
3. Cooperate with school personnel in assisting my child to comply with medication instructions.
4. Release Union Pointe Academy and their designated personnel from any liability concerning the administration or non-administration of the prescribed medication to the student.
5. Submit to school personnel any change in telephone numbers or emergency contacts.

Date _____ Parent/Guardian Signature _____

- All medication **must be brought to school by the parent/guardian** with this form completed.
- All medication **must be** in its original container as dispensed by the pharmacist or in its original packaging if it is an over-the-counter medication. The pharmacist's label must show the student's name, physician name, date, pharmacy name and telephone, name of medication, prescribed dosage and frequency, special handling and storage directions. If the medication is in liquid form, the parent must also bring a dispensing device.

THIS SECTION IS TO BE COMPLETED BY LICENSED PRESCRIBER
(Administration of medication should be scheduled before or after school hours whenever possible.)

Diagnosis	Medication	Dosage	Route

Time to be Administered	Date to Begin	Date to End
		(or end of school year-whichever is first)

Special Instructions for Administration: _____

Possible Side Effects: _____

Adverse Reactions to be reported to Licensed Prescriber: _____

Expected effects on learning: _____

Licensed Prescriber's Name	Licensed Prescriber's Signature	Date

Address	Phone Number	Fax Number

A NEW REQUEST FORM MUST BE SUBMITTED EACH SCHOOL YEAR OR FOR EACH NEW MEDICATION

Medication Log:

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Mat. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____ Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____

Date: _____ Medication: _____ Amt. Received_____Amt. taken_____
Total pills: _____ Witness Signature: _____ Staff Initials: _____